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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **GARY L. LOWERY, M.D.** Holder of License No. 24907 For the Practice of Allopathic Medicine In the State of Arizona, Respondent.	Board Case No. MD-02-0770 **AMENDED CONSENT AGREEMENT FOR LETTER OF REPRIMAND AND PROBATION**

RECITALS

In the interest of a prompt and judicious settlement of this case, consistent with the public interest, statutory requirements and responsibilities of the Arizona Medial Board ("Arizona Board"), and pursuant to A.R.S. §§ 32-1401 *et seq*. and 41-1092.07(F)(5), the undersigned party, Gary L. Lowery, M.D. ("Respondent"), holder of License No. 24907 to practice allopathic medicine in the State of Arizona, and the Board enter into the following Recitals, Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as the final disposition of this matter.

1. Respondent has read and understands this Consent Agreement as set forth herein, and has had the opportunity to discuss this Consent Agreement with an attorney or has waived the opportunity to discuss this Consent Agreement with an attorney. Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding the expense and

uncertainty of an administrative hearing.

2. Respondent understands that he has a right to a public administrative hearing concerning each and every allegation set forth in the above-captioned matter, at which administrative hearing he could present evidence and cross-examine witnesses. By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes all rights to such an administrative hearing, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action, concerning the matters set forth herein. Respondent affirmatively agrees that this Consent Agreement shall be irrevocable.

3. Respondent agrees that the Board may adopt this Consent Agreement, or any part thereof, pursuant to A.R.S. §§ 32-1401 *et seq*. and 41-1092.07(F)(5). Respondent understands that this Consent Agreement, or any part thereof, may be considered in any future disciplinary action against him.

4. Respondent understands that this Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. Respondent also understands that acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this state from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

5. Respondent acknowledges and agrees that, upon signing this Consent Agreement and returning it to the Board's Executive Director, Respondent may not revoke his acceptance of this Consent Agreement or make any modifications to it, regardless of whether this Consent Agreement has been issued by the Executive Director. Any modification to this original document is ineffective and void unless mutually approved by the parties in writing.

6. Respondent understands that the foregoing Consent Agreement shall not become effective unless and until adopted by the Board and signed by its Executive Director.

7. Respondent understands and agrees that if the Board does not adopt this Consent Agreement, he will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

8. Respondent understands that this Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

9. Respondent understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(r)(violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter) and may result in disciplinary action pursuant to A.R.S. § 32-1451.

DATED: 3/4/04

Gary L. Lowery MD, PhD
Gary L. Lowery, M.D.

Reviewed and Approved as to Form:

By: _____
Stephen W. Myers, Esq.

FINDINGS OF FACT

1. The parties stipulate that this Consent Agreement represents a compromise of a disputed matter between the Arizona Board and Respondent, and agree to the entry of this Consent Order for the purpose of terminating that disputed matter.

2. The Arizona Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

3. Respondent is the holder of License No. 24907 for the practice of allopathic medicine in the State of Arizona.

4. On or about March 21, 2001, the Florida Board of Medicine ("Florida Board") found that Respondent had negligently performed an anterior cervical fusion with plates on Patient R.L. in February 1992. (Final Order dated March 21, 2001, a true and correct copy of which is attached hereto as Exhibit 1 and incorporated herein by this reference.) Respondent had intended to perform the fusion at the C5-6 level of the cervical spine but, due to an error in reading the intraoperative fluoroscopic lateral spot films, he actually had performed the fusion at the C6-7 level. Although post-operative x-ray studies of the patient's spine in February, March and April 1992 clearly showed that he had operated on the wrong level of the spine, Respondent did not recognize and note his error in the patient's chart until July 1992. Accordingly, the Florida Board also found that Respondent failed to maintain medical records that justified his course of treatment for Patient R.L. The Florida Board found "no showing of malice, fraud, gross or repeated negligence or incompetency" and "no showing beyond simple mistake or negligence." (Exhibit 1, ¶ 60.)

5. Based upon those findings, the Florida Board issued Respondent a reprimand and ordered him to pay a $10,000 administrative fine. The Florida Board also ordered Respondent to attend 15 hours of Category I Continuing Medical Education ("CME"), including 10 hours of CME in the area of spine surgery and 5 hours in the area of medical ethics, within a year. Finally, the Florida Board ordered Respondent to complete a medical records course and perform 50 hours of community service consisting of the delivery of medical services directly to patients in Florida, both also within a year. (Final Order, Exhibit 1.)

6. Respondent timely appealed the Florida Board's order to the Florida court of appropriate jurisdiction, but a stay of the Board's Order was denied and Respondent's appeal was ultimately dismissed.

7. Respondent did not complete the CME and community service requirements within one year of the Florida Board's Order because: (a) he had already relocated his practice to Arizona; (b) the Florida Board's Order required that community service be performed in Florida; (c) his contract with his Arizona employer prohibited him from performing medical services outside the scope of his employment; and (d) his license to practice medicine in Florida had been placed on inactive status.

8. On or about October 29, 2002, the Florida Board accepted Respondent's offer to voluntarily relinquish his license to practice medicine in Florida. (Final Order dated October 29, 2002, a true and correct copy of which is attached hereto as Exhibit 2 and incorporated herein by this reference.)

9. On or about November 15, 2002, Respondent entered into a stipulation with the Medical Board of California ("California Board") for a public reprimand based upon the Florida Board's action of March 21, 2001. (Decision adopting Stipulation for Public Reprimand dated November 15, 2002, a true and correct copy of which is attached hereto as Exhibit 3 and incorporated herein by this reference.)

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter and over Respondent pursuant to A.R.S. § 32-1401 *et seq*.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(o)(action taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, his medical incompetence or for unprofessional conduct as defined by that jurisdiction and which corresponds directly or indirectly to an act

of unprofessional conduct proscribed by Arizona law. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction.).

3. The Florida Board took action against Respondent's license to practice medicine in the State of Florida on the basis of certain findings of unprofessional conduct in its Final Order dated March 21, 2001. Those findings of unprofessional conduct correspond directly or indirectly to the following acts of unprofessional conduct proscribed by Arizona law:

A. Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of the patient. A.R.S. § 32-1401(26)(ll). Negligence is a failure to exercise that degree of care, skill and learning expected of a reasonable, prudent physician or specialist in Arizona in the same or similar circumstances. A.R.S. §§ 1-215(25) and 12-563.

B. Failing or refusing to maintain adequate records on a patient. A.R.S. § 32-1401(26)(e). An adequate medical record is a "legible medical record" that contains "at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment." A.R.S. § 31-1401(2).

4. The Florida Board took a second action against Respondent's license when it accepted his offer to voluntarily relinquish his license to practice medicine in the State of Florida in its Final Order dated October 29, 2002. That action corresponds directly or indirectly to the following act of unprofessional conduct proscribed by Arizona law:

A. Action taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's . . . unprofessional conduct as defined by that jurisdiction and which corresponds directly or indirectly to an act of unprofessional conduct proscribed by Arizona law. The action taken may include . . . a surrendering of a license to that jurisdiction . . . . A.R.S. § 32-1401(26)(o).

5. The California Board took action against Respondent's license to practice medicine in the State of California on the basis of certain findings of unprofessional conduct in its Decision dated November 15, 2002. Those findings of unprofessional conduct correspond directly or indirectly to the following acts of unprofessional conduct proscribed by Arizona law:

A. Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of the patient. A.R.S. § 32-1401(26)(ll). Negligence is a failure to exercise that degree of care, skill and learning expected of a reasonable, prudent physician or specialist in Arizona in the same or similar circumstances. A.R.S. §§ 1-215(25) and 12-563.

B. Failing or refusing to maintain adequate records on a patient. A.R.S. § 32-1401(26)(e). An adequate medical record is a "legible medical record" that contains "at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment." A.R.S. § 31-1401(2).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and pursuant to the authority granted to the Board by A.R.S. §§ 32-1401 *et seq*. and 41-1092.07 (F)(5), IT IS HEREBY ORDERED that:

1. Respondent shall be issued a Letter of Reprimand for having had actions taken against him by other licensing or regulatory jurisdictions due to unprofessional conduct as defined by those jurisdictions and which correspond directly or indirectly to acts of unprofessional conduct proscribed by Arizona law—that is, negligence resulting in harm to a patient and failure to maintain adequate medical records.

2. Respondent shall be placed on Probation for one (1) year with the following terms and conditions:

A. Respondent shall, within one (1) year of the effective date of this Order, obtain 20 hours of Board staff pre-approved Category 1 CME in the following areas: ten (10) hours of CME in spine surgery, five (5) hours in medical ethics, and five (5) hours in medical record-keeping. Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

B. Respondent shall, within one (1) year of the effective date of this Order, perform fifty (50) hours of community service. Such community service shall be performed outside the physician's regular practice setting. Respondent shall submit a written plan for the performance and completion of the community service to Board staff for pre-approval. Respondent shall provide Board staff with satisfactory proof of performance of the community service.

C. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

D. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. The declarations must be submitted on or before the 15th of March, June, September and December of each year.

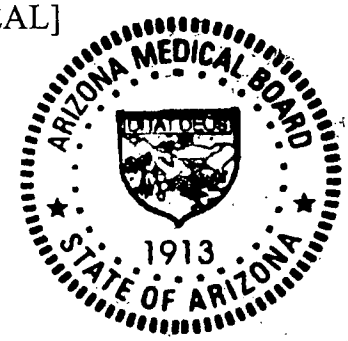
E. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten (10) days of departure or return or the dates of non-practice in Arizona. Non-practice is defined as any period of time exceeding thirty (30) days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona will not affect the one-year deadline for completing the CME and community service requirements outlined in paragraphs 2(A) and (B) above.

3. This Order is the final disposition of case number MD-02-0770.

DATED this 17th day of March, 2004.

ARIZONA MEDICAL BOARD

[SEAL]



By: Barry A. Cassidy
BARRY A. CASSIDY, Ph.D., P.A.-C
Executive Director

ORIGINAL OF THE FOREGOING FILED
this 17th day of March, 2004, with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY OF THE FOREGOING
MAILED BY CERTIFIED MAIL
this 17th day of March, 2004, to:

Gary L. Lowery
Respondent
(Address of Record on file with the Board)

EXECUTED COPIES OF THE FOREGOING MAILED
this 17th day of March, 2004, to:

Stephen W. Myers
MYERS & JENKINS, P.C.
3003 N. Central Avenue Suite 1900
Phoenix, Arizona 85012
Attorneys for Respondent

Stephen A. Wolf, Esq.
Assistant Attorney General
1275 W. Washington Street, CIV/LES
Phoenix, AZ 85007
Attorneys for the State of Arizona

Planning & Operations

EXHIBIT #1

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Final Order No. DOH-01-0372-FOF-MQA
FILED DATE - 3/21/01
Department of Health
By: Vicki R. Kenon
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 1994-07642
DOAH CASE NO.: 99-5034
LICENSE NO.: ME0053531

GARY LYNN LOWERY, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on February 2, 2001, in Tampa, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order and the Petitioner's Motion to Increase Penalty (copies of which are attached hereto as Exhibits A and B) in the above-styled cause. Petitioner was represented by Larry G. McPherson, Jr., Senior Prosecuting Attorney. Respondent was not present but was represented by William E. Ruffier, Esquire.

Upon review of the Recommended Order, the argument of the parties, and after a review of the complete record in this case, the Board makes the following findings and conclusions.

FINDINGS OF FACT

1. The findings of fact set forth in the Recommended Order are

approved and adopted and incorporated herein by reference.

2. There is competent substantial evidence to support the findings of fact.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 458, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

3. There is competent substantial evidence to support the conclusions of law.

RULING ON MOTION TO INCREASE PENALTY

The Board reviewed and considered the Petitioner's Motion to Increase Penalty and GRANTED the Petitioner's Motion to Increase Penalty for the reasons stated by Petitioner and set forth in the record.

PENALTY

Upon a complete review of the record in this case, the Board determines that the penalty recommended by the Administrative Law Judge be REJECTED based upon the record and for the reasons stated by Petitioner. Specifically, the record reflects that Respondent performed an operation on a patient at the wrong level and failed to document the surgical mistake in the patient's medical records, and failed to inform the patient of the error for six months after he had knowledge the surgery was performed at the wrong site. The Board determines that these factors warrant an increase in the penalty

recommended by the Administrative Law Judge.

WHEREFORE, IT IS HEREBY ORDERED AND ADJUDGED that:

1. Respondent shall pay an administrative fine in the amount of $10,000 within six (6) months from the date this Final Order is filed.

2. Respondent shall be and hereby is REPRIMANDED.

3. Respondent shall attend fifteen (15) hours of Category I Continuing Medical Education within one year from the date this Final Order is filed as follows: ten (10) hours shall be in the area of spine surgery and five (5) hours shall be in the area of medical ethics. Respondent shall submit a written plan to the Chairperson of the Probationer's Committee for approval prior to the completion of said courses. The Board confers authority on the Chairperson of the Probationer's Committee to approve or disapprove said continuing education courses. In addition, Respondent shall submit documentation of completion of this continuing medical education to the Probationer's Committee Chairperson. These hours shall be in addition to those hours required for biennial renewal of licensure. Unless otherwise approved by the Board or the Chairperson of the Probationer's Committee, said continuing education courses shall consist of a formal live lecture format.

4. Respondent shall document completion of the medical records course sponsored by the Florida Medical Association, or an equivalent course approved by the Chair of the Board's Probationer's Committee within one (1) year from the date this Final Order is filed.

5. During the next 12 months from the date this Final Order is

filed, Respondent shall perform 50 hours of community service. Community service shall consist of the delivery of medical services directly to patients, without fee or cost to the patient, for the good of the people of the State of Florida. Such community service shall be performed outside the physician's regular practice setting. Respondent shall submit a written plan for performance and completion of the community service to the Probationer's Committee for approval prior to performance of said community service. Affidavits detailing the completion of community service requirements shall be filed with the Board Said approved by Chair of Probationer's Committee.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 21st day of February, 2001.

BOARD OF MEDICINE

Tanya Williams
for GASTON ACOSTA-RUA, M.D.
CHAIRMAN

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF

APPEAL WITH THE AGENCY CLERK OF THE AGENCY FOR HEALTH CARE ADMINISTRATION AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to Gary Lynn Lowery, M.D., 10645 North Tatum Boulevard, Suite 200, #614, Phoenix, Arizona 85028; to William E. Ruffier, Esquire, P.O. Box 753, Orlando, Florida 32802; to Ella Jane P. Davis, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; and by interoffice delivery to Kathryn L. Kasprzak, Chief Medical Attorney, and Simone Marstiller, Senior Attorney - Appeals, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this _____ day of _____, 2001.

_____

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner,	)	
vs.	)	Case No. 99-5034
GARY LYNN LOWERY, M.D., Respondent.	)	

RECOMMENDED ORDER

Upon due notice, a formal hearing was held in this case on September 13, 2000, in Gainesville, Florida, before the Division of Administrative Hearings, by its designated Administrative Law Judge, Ella Jane P. Davis.

APPEARANCES

For Petitioner: Robert C. Byerts, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32399-4229

For Respondent: William E. Ruffier, Esquire
108 East Central Boulevard
Post Office Box 753
Orlando, Florida 32802-0753

STATEMENT OF THE ISSUE

Whether Respondent medical physician violated Subsection 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill and treatment recognized by a

A

reasonably prudent similar physician as being acceptable under similar conditions and circumstances; Subsection 458.331(1)(m), Florida Statutes, by failing to keep medical records to justify the course of treatment of a patient; and/or Subsection 458.33(1)(p), Florida Statutes, by performing surgery at the spinal level of C6-7 without patient consent and without statutory exception.

PRELIMINARY STATEMENT

This case was tried upon an Amended Administrative Complaint referred to the Division of Administrative Hearings on December 3, 1999. By agreement of the parties, the case was initially set for hearing on April 12 and 13, 2000. Also, by request and agreement of the parties, it was continued to July 6 and 7, 2000, and finally to September 13 and 14, 2000. The disputed-fact hearing ultimately required only a one-day hearing on September 13, 2000.

At hearing, Petitioner moved for official recognition of Chapter 458 (particularly Section 458.331), Florida Statutes, and Chapter 64B8-8, Florida Administrative Code. An oral order was entered providing for Petitioner to file, after the hearing, copies of these items as they were worded at all times material and for Respondent to timely object thereafter if the hard copies did not reflect the applicable statutes and rules on the material date(s). On September 14, 2000, Petitioner filed

statutory copies, and on September 28, 2000, Petitioner filed rule copies. There having been no timely objection by Respondent, the rule language contained in these copies have been utilized and applied herein, even though the rule numbers are different than originally requested.

Respondent moved for dismissal of Count III of the Amended Administrative Complaint, relating to lack of patient authorization, which was denied orally, subject to re-visitation in this Recommended Order.

The parties' Joint Pre-hearing Stipulation and oral stipulations during hearing have also been utilized herein, although not verbatim. The recognized Request for Admissions has also been utilized.

At hearing, Petitioner presented the oral testimony of patient R.L. and of Manuel Gonzalez-Perez, M.D. and had 12 exhibits admitted in evidence. Dr. Gonzalez-Perez was accepted as an expert in general orthopedics and spinal surgery.

Respondent presented the oral testimony of Richard Smith, M.D., and testified on his own behalf. Respondent had three exhibits admitted in evidence. Dr. Smith was accepted as an expert in spinal surgery.

Because the parties had failed to redact R.L.'s name from the exhibits, the undersigned instructed the court reporter to

substitute the patient's initials in the transcript and has arranged to return all exhibits to the Board under seal.

A Transcript was filed with the Division on October 26, 2000. Each party's timely-filed Proposed Recommended Order has been considered.

FINDINGS OF FACT

1. Petitioner, through the Board of Medicine, is the state agency which licenses and has regulatory jurisdiction of medical physicians.

2. At all times material, Respondent has been a licensed medical physician in the state of Florida, having been issued license No. ME 0017399. He is board-certified in orthopedic surgery, is a member of many spine-specialized medical societies, and is highly published in the field of spinal surgery. He has devoted 100 percent of his practice to spinal surgery since 1989.

3. On or about August 16, 1991, Patient R.L., then a thirty-two-year-old woman, was referred to Respondent with complaints of neck and shoulder pain due to a work-related accident.

4. On August 16, 1991, Respondent diagnosed R.L. as having cervical spondylosis with radiculopathy, and thoracolumbar scoliosis. He recommended she undergo magnetic resonance

imaging (MRI) of her cervical spine at North Florida Regional Medical Center (NFRMC).

5. R.L. underwent MRI of her cervical spine at NFRMC on September 20, 1991. The radiologist's report of R.L.'s September 20, 1991, MRI indicated no disc herniation, central stenosis, or foraminal impingement at the C3-4 and C4-5 disc levels or at the C6-7 and C7-T1 levels.

6. The radiologist's report did indicate that at the C5-6 level there was a small abnormal posterior protrusion of disc material, centrally and slightly eccentric towards the right side and that axial images demonstrated a small, right-sided central/right paracentral herniation. The report added that a very mild and early uncontrovertral spurring was noted at this level but was not resulting in impingement for exiting nerve roots.

7. R.L. next saw Respondent on September 24, 1991. On that date, Respondent reviewed R.L.'s cervical spine MRI with her and diagnosed a probable small central and right paracentral herniation at the C5-6 level. Respondent was then of the opinion that the cervical spine MRI did not clearly delineate a disc herniation at R.L.'s C5-6 level. Respondent accordingly recommended that R.L. undergo a myelogram-CT scan. Respondent did not indicate to R.L. that he detected any pathology at C6-7.

8. On October 29, 1991, R.L. underwent a cervical myelogram and CT scan at NFRMC. The radiologist's report indicated an extradural defect at C5-6, which was moderate in size and touched the cord but which did not cause any cord compression. The report also stated that the nerve sleeved well and that there was a very slight posterior subluxaton of C5 on C6 associated with this. The report did not indicate any pathology at C6-7.

9. R.L. next saw Respondent on November 14, 1991. On that date, Respondent reviewed R.L.'s cervical myelogram and CT scan with her, diagnosed a herniated nucleus pulposus at C5-6, and recommended C5-6 anterior cervical fusion with plates. Respondent did not, on that date, indicate to R.L. that he had identified any pathology at C6-7.

10. R.L. testified that before surgery, Respondent did not tell her that he would be removing any disc other than the one at C5-6; that he did not indicate he thought R.L. would need more surgery than the surgery planned at C5-6; or that he might discover something during the planned surgery which would require the removal of any disc different than C5-6.

11. Respondent testified that he did not recall whether he did or did not tell R.L. that C6-7 might some day require an operation or that C6-7 might need work while he was operating on C5-6. His office notes for January 21, 1992, only state

> She returns today for her preoperative visit. The nature and extent of her surgery has been explained to her and she voices understanding.

12. R.L.'s and Respondent's testimony agree that before surgery, Respondent intended to remove and fuse only at C5-6; that R.L. understood and agreed that Respondent would remove only the disc at level C5-6 and fuse it; and that before surgery, neither of them expected Respondent to operate at a level of R.L.'s cervical spine different than C5-6.

13. Experts for Petitioner and Respondent, (Drs. Gonzalez-Perez and Smith respectively), concurred that if Respondent discussed the proposed procedure, most common and potential risks and complications, and the potential course of rehabilitation with R.L., and if Respondent and R.L. then reached a mutual decision to operate, full disclosure and informed consent had occurred, regardless of whether a written consent form had been filled out and signed.

14. On January 29, 1992, R.L. signed an NFRMC "Authorization for Surgical Treatment and/or Special Procedure" which provided:

> I, the undersigned, a patient in the below named hospital, hereby authorize Dr. Lowery (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following operation: anterior cervical fusion and instruments with autolugus and/or bone bank bone and such additional operations or

> procedures as are considered therapeutic on the basis of findings during the course of said operation. I also consent to the administration of such anesthetics as are necessary with the exception of none. Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice. I hereby certify that I have read and fully understand the above AUTHORIZATION FOR SURGICAL TREATMENT, the reasons why the above-named surgery is considered necessary, its advantage and the possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Lowery. I also certify that no guarantee or assurance has been made as to the results that may be obtained (Underlined portions were written in; the remainder was pre-printed).

15. The foregoing hospital authorization did not identify the level of the cervical spine where the procedure would be performed. It merely indicated that an anterior cervical fusion would be performed, without stating which of the seven vertebrae were intended to be fused. Dr. Gonzalez-Perez, Petitioner's expert witness, testified that this is not the type of release a reasonable and prudent physician would use for informed consent.

16. Petitioner contends that Respondent's use of the authorization form deviated from the level of care, skill, and treatment recognized by a reasonable and prudent physician as being acceptable under similar facts and circumstances, but even Petitioner's expert, Dr. Gonzalez-Perez, testified that such a form is usually filled-out by a nurse employed by the hospital, and that if Respondent and R.L. went through an informed consent

conversation prior to surgery, that would be sufficient, without a written acknowledgement or authorization, for Respondent to have met the standard of care for informed consent and patient pre-authorization for surgery at the mutually understood level of C5-6.

17. On February 3, 1992, Respondent performed an anterior cervical fusion with plates on R.L. at NFRMC, with the intention of operating at the C5-6 level of R.L.'s cervical spine. In doing so, he utilized a portable fluoroscopy unit, intraoperatively, to ascertain the correct level of R.L.'s cervical spine for the anterior cervical fusion with plates.

18. The success of such a procedure depends upon properly identifying the pathological discs. It is critical to correctly ascertain the site where the surgery is to be performed. Failure to correctly identify the location for surgery can result in a failure to perform the intended surgery, a failure to resolve the problem which required the surgery, and/or performing surgery in a location not requiring surgery.

19. The method Respondent used was to palpate the boney structures, make an incision to the vertebral bodies, insert a single needle, take an X-ray, and see if the needle had correctly located where surgery should take place.

20. Respondent's expert, Dr. Smith, and Respondent testified that they prefer the one-needle method utilized by Respondent.

21. Dr. Gonzalez-Perez admitted that use of X-rays, including fluoroscopy in the operating room in order to locate the level of the operation is the "gold standard" of care in this type of orthopedic surgery. He would have used a two-needle technique for locating and checking the location of the surgical site, but even he considered the one-needle method to constitute acceptable medical practice.

22. In R.L.'s case, Respondent placed the single needle at the C7-T1 level, and the fluoroscopic lateral spot films of R.L.'s cervical spine obtained in the operating room showed the needle at the C7-T1 level.

23. Respondent, however, concluded incorrectly that the fluoroscopic lateral spot films showed a needle at the C6-7 level. Respondent miscounted from the vertebra landmark of what he thought was C-2, and removed and fused the wrong disc.

24. On February 3, 1992, after drawing the conclusion that the intraoperative fluoroscopic lateral spot films showed a needle at the C6-7 level of R.L.'s cervical spine, Respondent proceeded with an anterior cervical fusion with plates at what he assumed was the C5-6 level of R.L.'s cervical spine, which, in fact, was the C6-7 level. Respondent, in fact, performed an

anterior cervical fusion with plates at the C6-7 level of R.L.'s cervical spine.

25. Respondent surmised in his testimony that he had been confused because on R.L., the C-2 and C-3 structures were very similar.

26. Dr. Gonzalez-Perez maintained that Respondent should have been able to locate the correct level based on the jaw bone and part of the skull being visible in the first and pre-removal X-ray (lower image of P-7). Respondent disagreed that skull and jaw are the best landmarks.

27. Dr. Smith testified that C-2 and C-3 look similar due to their scalloped edges, but either would be an appropriate point from which to begin counting. He, personally, would normally begin counting with C-2, which is a very distinctive-looking vertebra. He opined that even reasonable and prudent physicians can make mistakes in counting and removing the wrong disc.

28. Dr. Gonzalez-Perez felt that Respondent could have and should have involved others in the operating room in counting vertebrae and selecting the surgical location. Respondent disagreed, maintaining that only the surgeon should make such a decision. Dr. Smith testified that he, personally, asks someone else in the operating room to check him after he has counted.

29. Petitioner contends that by failing to correctly identify the level of the spine and to make certain of the operative level before proceeding, Respondent failed to practice with the level of care, skill and treatment which is recognized by a reasonable and prudent medical physician under similar facts and circumstances as being acceptable and that Respondent had the information and should have been able to properly and correctly count the levels of the cervical spine and find the appropriate disc. However, even Petitioner's expert, Dr. Gonzalez-Perez, testified that Respondent met the standard of care up to the point at which Respondent performed the actual operation, and that operating at an unintended level is a known complication of such surgery, as stated in the textbooks.

30. Respondent testified that during the surgery, he found a disc fragment and a tear in the posterior longitudinal ligament (PLL) at the wrong level (C6-7) where he removed the wrong disc, and that during the surgery, he relied upon this discovery as indicative that he was operating at the correct location/level (C5-6).

31. Respondent testified that he removed the piece of disc at C6-7 in one piece, found a rent in the PLL behind it, and believed the pathology he had found corresponded to what he had expected to find at the C5-6 level, based on his preoperative evaluation.

32. Dr. Gonzalez-Perez testified that a rent in the PLL cannot be seen until the disc is removed, so viewing it does not verify the location at which a discectomy should occur. He also stated that although a surgeon tries not to push down, occasionally s/he must dig in and push tissue to the back so as to remove the desired tissue and that portions of the disc may remain in the disc space until they are scooped out. Therefore, the procedure itself can result in a tear of the PLL.

33. In light of the pre-operative tests not showing disc material or a PLL tear, Petitioner urges that the conclusion be drawn that Respondent's surgery itself caused the tear and protrusion at R.L.'s C6-7 level, but Dr. Gonzalez-Perez did not clearly state such a conclusion.

34. Dr. Smith testified that finding such pathology after beginning the disc removal would have been a comforting (re-enforcing) sign to any surgeon that s/he had operated at the correct level, but Dr. Smith acknowledged that such a sign would not identify the correct disc for removal before removal actually began.

35. Due to the superiority of Respondent's and Dr. Smith's cervical spine surgical experience over that of Dr. Gonzalez-Perez, who does only an average of two cervical spine operations per year, and due to Respondent's explanation of how the PLL/annulus structures differ in the cervical spine from the

lumbar spine, it is found that even if the Respondent did not see the disc fragment and PLL rent until after he began removal of the C6-7 disc, the pathology at C6-7 reasonably reinforced Respondent's belief that he was operating in the correct location of C5-6 for the duration of the operation.

36. No one clearly testified that the C6-7 removal and fusion was necessary on February 3, 1992, or that it would become necessary at some later date.

37. Likewise, no one clearly testified that the removal and fusion at C6-7 was not necessary on February 3, 1992, or would not have become necessary later.

38. Dr. Smith testified that in his pre-operative discussions with his own patients, they usually tell him to fix any additional unexpected pathology he finds once he begins an operation.

39. The evidence falls short of being clear and convincing that the wrong disc removal and fusion on February 3, 1992, resulted in any subsequent damage to R.L.'s spine.

40. While still in the operating room, Respondent checked his work with a second fluoroscopic image (upper image of P-7). Respondent and both experts agreed that this second image would cause a surgeon who thought he had counted correctly to assume he had removed the correct disc and created a good fusion at the correct level. However, the two experts concurred that there

were no clear landmarks whatsoever on this view to show that the operation had occurred at either the correct or the incorrect level.

41. Respondent's operative report for the February 3, 1992, procedure incorrectly described removal of the C5-6 disc space.

42. On February 4, 1992, postoperative X-rays taken at NFRMC showed that the anterior cervical fusion with plates had, in fact, been performed at the wrong level, C6-7, of R.L.'s cervical spine. Copies of the report concerning the X-rays were supplied to Respondent at about that time. About a week later, the radiologist's narrative to the same effect was provided to Respondent. Nonetheless, Respondent did not discover his error for nearly six months.

43. After the surgery, R.L. continued to experience pain, presumably because she still had the same uncorrected, pre-operative problem at C5-6.

44. R.L. returned to Respondent on an outpatient basis on February 11, 1992. On that date, Respondent performed a radiographic examination of R.L.'s cervical spine but made no mention to her that the anterior cervical fusion with plates had been performed at the wrong level. He made no such notation in her chart. Respondent told R.L. that he had looked at the X-rays and everything had gone well and everything looked good.

45. R.L. next saw Respondent on March 12, 1992, when he again performed a radiographic examination of R.L.'s cervical spine. At that time, Respondent made no mention of the C6-7 level of the anterior cervical fusion with plates in her chart and again did not tell R.L. that he had removed the wrong disc and fused the wrong location.

46. R.L. next saw Respondent on April 23, 1992, and again Respondent did not reveal his error to R.L., but he did make a narrative note to her chart which stated that R.L. "is now approximately eleven weeks from having an ACF, C6-7."

47. Even so, Respondent did not discover he had operated on the incorrect level until R.L.'s July 23, 1992 visit, at which time, he informed R.L. what had occurred.

48. Respondent's July 23, 1992, narrative note for R.L.'s chart makes the statement that

> I have explained that there is a discrepancy in her clinical exam and also the intraoperative findings and postoperative x-rays, both to the patient and her rehabilitation counselor, Ms. Terry L. Smith, R.N.

49. Respondent clearly remembered the presence of the nurse on July 23, 1992.[1]

50. Dr. Gonzalez-Perez opined that Respondent's performance was acceptable up to the operation itself, but was not up to the acceptable level of care thereafter, because from

the first (lower image P-7) fluoroscopy image, Respondent should have been able to tell the needle was on the wrong level by counting vertebrae; because Respondent should have involved others in the operating room in analyzing the X-ray; because Respondent should not have removed the C6-7 disc, based on his own preoperative work-up; and because Respondent should not have relied on the rent and fragmentation at C6-7 to confirm his conclusion that he was operating at the correct level/location.

51. Dr. Gonzalez-Perez faulted Respondent's record-keeping for failing to write in a recommendation; because his records did not justify the removal and fusion at C6-7; and because Respondent did not follow his own initial surgical plan.

52. Ultimately, however, Dr. Gonzalez-Perez testified that it is not "malpractice" to operate at the wrong level, provided the error is discovered at the end of the operation, because one may decide to re-operate correctly.

53. Dr. Smith's opinion was that an acceptable level of care had been met if Respondent informed the patient of his error once he discovered it.

54. There is no dispute that at the July 1992 office visit, Respondent offered to do the C5-6 surgery for R.L. immediately.

55. Respondent has had no prior or subsequent disciplinary actions against him. This event occurred three years after he

began to devote himself exclusively to spinal surgery. Eight years have passed since this event. There is no evidence of any other level of practice problem of any kind.

CONCLUSIONS OF LAW

56. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties to this cause pursuant to Section 120.57(1), Florida Statutes.

57. The duty to go forward and burden of proof by clear and convincing evidence is upon Petitioner. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

58. Respondent is charged under the following 1991 statutes:

> 458.331(1) Grounds for disciplinary action; action by the board department. --
> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken.
>
> * * *
>
> (m) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispenses, or administered; and reports of consultations and hospitalizations.
>
> * * *
>
> (p) Performing professional services which have not been duly authorized by the patient or client, or his legal representative, except as provided in s. 743.064 s. 766.103, or 768.13.

* * *

> (t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. . . . As used in this paragraph 'gross malpractice' or 'the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances,' shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

59. As to Count I of the Amended Administrative Complaint, it is concluded that Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. Respondent took and looked at the first intraoperative X-ray, miscalculated, did not call on other staff to assist in identifying the location level of operation, removed the wrong disc, took his own second X-ray without adequate landmarks, and failed to document accurately what he had actually done. He also failed to recognize his error in a timely manner. For six months, he did not connect the February 4, 1992, radiologist's report of a fusion at C6-7 with his pre-operative plan to fuse at C5-6. For six months, he

took and looked at X-rays showing the C6-7 fusion and did not see the continuing problem at C5-6 despite R.L.'s complaints of pain. Nor, by comparing his pre-surgical plan to successive post-operative X-rays, did he see that he had operated at the wrong level of C6-7. Consequently, he also repeatedly failed to document in the patient's chart and/or his office notes that he had operated at the wrong level. See Section 458.331(1)(t), Florida Statutes, and Agency for Health Care Administration v. Sanchez, DOAH Case No. 95-3925 (Recommended Order entered October 19, 1995; Final Order entered January 26, 1996).

60. There is, however, no showing of malice, fraud, gross or repeated malpractice, or incompetency. There is no showing beyond simple mistake or negligence. There are, however, many mitigating factors. See Conclusion of Law 66.

61. For the same reasons, it is concluded as to Count II of the Amended Administrative Complaint that Respondent failed to keep medical records that justified the course of treatment of the patient because Respondent persisted in documenting an operation according to plan in the face of reports and X-rays pointing to a C6-7 operation at the wrong level having been performed. No evidence herein shows the C6-7 operation to have been necessary. See Section 458.331(1)(m), Florida Statutes, and Agency for Health Care Administration v. Sanchez, supra.

62. Respondent has moved to dismiss Count III of the Amended Administrative Complaint on the theory that it is solely addressed to the hospital authorization form. Respondent contends that the evidence shows it was not Respondent's form, that he received an oral informed consent from R.L., and that both medical experts testified that as long as Respondent and patient went through an oral process of informed consent, then Respondent met the appropriate standard of care. Respondent further asserts, that Subsection 458.331(1)(p), Florida Statutes, implies proscription only of an intentional act to perform services not authorized by the patient.

63. The motion is denied. The evidence does show that the authorization form was that of the hospital, not Respondent's form, and that Respondent fulfilled the necessary functions associated with getting R.L.'s oral authorization of a discectomy and fusion at C5-6. However, Respondent did not get authorization from R.L. for an operation at C6-7. Respondent may not be prosecuted for the flaws of the hospital authorization form in its failure to name the proposed level of operation. Respondent likewise cannot rely on its language permitting him "to perform . . . such additional operations or procedures as are considered therapeutic on the basis of findings during the course of said operation," (see Finding of Fact 14), in the face of R.L.'s unrefuted testimony that

Respondent never explained to her the risks of removing the wrong disc and that he never got her agreement that he could repair other structures he found damaged after he had commenced the operation (see Findings of Fact 10-11).

64. Under these circumstances, when he operated at C6-7 instead of C5-6, Respondent violated Subsection 458.331(1)(p), Florida Statutes, by performing professional services which had not been duly authorized by the patient. See Agency for Health Care Administration v. Sanchez, supra. Sections 743.064, 766.103, and 768.13, Florida Statutes, are irrelevant here.

65. By the terms of Rule 21M-20.001, Florida Administrative Code, the Board of Medicine may impose discipline ranging from two years of probation to revocation of license and an administrative fine from $250.00 to $5,000.00 for violating Subsection 458.331(1)(a), Florida Statutes, but that rule is predicated on a finding of "malpractice." For violating Subsection 458.331(1)(m), Florida Statutes, the rule provides for a reprimand or two years' suspension followed by probation and an administrative fine from $250.00 to $,5000.00. For a violation of Subsection 458.331(1)(p), Florida Statutes, the penalty range is from a reprimand to two-year suspension and an administrative fine from $250.00 to $5,000.00.

66. Having said that, it is noted that Respondent has had an exemplary record over the eight years and hundreds of

cervical spine operations intervening since this single incident; that his 1992 operational error did not affirmatively harm the patient but merely delayed alleviation of her pain; and that it is unclear whether the operation he performed at the wrong level might eventually have had to be performed anyway.

67. It is also noted that the highly qualified Dr. Smith considered that Respondent met the level of care in most respects, and that even Petitioner's Proposed Recommended Order prays for relief only as follows: "It is concluded that an administrative fine of $5,000 is more than reasonable in addition to a reprimand." (Emphasis supplied)

68. Upon consideration, it is concluded that this case does not warrant a "more than reasonable" penalty. By applying Rule 21M-20.001(3)(a), (c), (d), (e), (f), and (g), including but not limited to the factors specifically outlined in Conclusions of Law 60 and 66-67, that an appropriate penalty is a reprimand and a $750.00 fine.

RECOMMENDATION

Based upon the Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That the Board of Medicine enter a final order finding Respondent guilty of violating Subsections 458.331(1)(m), (p), and (t), Florida Statutes, with mitigating circumstances, reprimanding him for same, and imposing a $750.00 fine.

DONE AND ENTERED this 28th day of December, 2000, in Tallahassee, Leon County, Florida.

ELLA JANE P. DAVIS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of December, 2000.

ENDNOTE

[1]/ Because of R.L.'s vagueness about dates and the evidence of the office notes, I have accepted Respondent's testimony that he only discovered or was sure of his error in July and immediately told R.L. and her nurse and have discounted R.L.'s testimony that on either the second or third visit, which would have been the March or April visit, while her nurse was with her, Respondent told her there was a "discrepancy" which reduced R.L. to tears and that Respondent waited until she was alone in July to tell her that he had removed and fused the wrong disc.

COPIES FURNISHED:

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Agency for Health Care Administration
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Tanya Williams, Executive Director
Department of Health
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Tallahassee, Florida 32399-1701

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.

EXHIBIT #2

Final Order No. DOH-02-1635-S-MQA
FILED DATE - 10/29/02
Department of Health
By: Vicki R. Kenon
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH Case No.: 2002-11794
License No.: ME0053531

GARY LYNN LOWERY, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on October 4, 2002, in Miami, Florida, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 27 day of OCTOBER, 2002.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
for Zachariah P. Zachariah, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to GARY LYNN LOWERY, M.D., 10645 N. Tatum Boulevard, Suite 200, #614, Phoenix, Arizona 85024; to Richard L. Barry, Esquire, McEwan, Martinez, et al., P.A., P.O. Box 753, Orlando, Florida 32802-0753; and by interoffice delivery to Ephraim Livingston and Pamela Page, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3265 this 29 day of October, 2002.

Kim Webb

F:\Users\ADMIN\NANCY\MED\CRD\10-02-Disc\Lowery.wpd

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

v. DOH Case Number: 2002-11794

GARY LYNN LOWERY, M.D.,

Respondent.
_____/

VOLUNTARY RELINQUISHMENT OF LICENSE

To avoid the necessity of further administrative proceedings in this case, the Respondent herein files this Voluntary Relinquishment of his license to practice as a medical doctor in the State of Florida, with the provision that the Respondent agrees never again to apply for licensure as a medical doctor in the State of Florida.

When relinquishments are offered to avoid further administrative prosecution, this is considered to be disciplinary action against the Respondent's license to practice medicine in the State of Florida. As such, any and all disciplinary actions taken by the Department are reported to the Federation of State Medical Boards and the National Practitioner Data Bank.

Respondent expressly waives the finding of probable cause in this complaint. Upon the adoption of this Relinquishment, Respondent expressly waives all further procedural steps. Moreover, Respondent expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Relinquishment and the Final Order of the Department incorporating said Relinquishment.

Upon the adoption of this Relinquishment, the parties hereby agree that each party will bear his own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Agency in connection with this matter.

This Relinquishment is executed by the Respondent for the purpose of avoiding further administrative action with respect to this cause. In this regard, Respondent authorizes the Department of Health to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Relinquishment. Furthermore, should this Relinquishment not be accepted by the Department, it is agreed that presentation to and consideration of this Relinquishment and other documents and matters by the Department shall not unfairly or illegally prejudice the Department or any of its members from further participation, consideration or resolution of these proceedings.

DATED this 29th day of July, 2002.

Gary L. Lowery M.D., PhD
GARY LYNN LOWERY, M.D.

STATE OF Arizona
COUNTY OF: Maricopa

Before me, personally appeared Gary L. Lowery M.D., PhD, whose identity is known to me by Driver License (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 29th day of July, 2002.

Richard K Bingham

NOTARY PUBLIC
STATE OF ARIZONA
Maricopa County
RICHARD K. BINGHAM
My Appointment Expires 08/07/02

EXHIBIT #3

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation filed Against:	)	
GARY LYNN LOWERY, M.D. Certificate No. G-50591	)	No: 16-2001-121085
Respondent	)	

DECISION

The attached Stipulation for Public Reprimand is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on November 15, 2002

IT IS SO ORDERED October 16, 2002

By: _____
RONALD WENDER, M.D.
Chair - Panel B
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: GARY LYNN LOWERY, M.D. 10645 North Tatum Blvd., Suite 200 Phoeniz, AZ 85028 Physician and Surgeon's Certificate No. G 50591, Respondent.	Case No. 16-2001-121085 STIPULATION FOR PUBLIC REPRIMAND

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

1. An Accusation in case number 16-2001-121085 was filed with the Division of Medical Quality, of the Medical Board of California, Department of Consumer Affairs (the "Division") on August 7, 2001, and is currently pending against Gary Lynn Lowery, M.D. (the "respondent").

2. At all times relevant herein, respondent has been licensed by the Medical Board of California under Physician and

Surgeon's Certificate No. G 50591, issued by the Board to respondent on or about July 5, 1983. Said certificate is current with an expiration date of May 31, 2003.

3. The Accusation, together with all statutorily required documents, was duly served on the respondent and respondent filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 16-2001-121085 is attached as Exhibit "A" and hereby incorporated by reference as if fully set forth.

4. The Complainant, Ronald Joseph, is the Executive Director of the Medical Board of California and brought this action solely in his official capacity. The Complainant is represented by the Attorney General of California, Bill Lockyer, by and through Supervising Deputy Attorney General, Gail M. Heppell.

5. Respondent is represented by Charles O. Thompson, Esq., Hinshaw & Culbertson, 244 Jackson, Suite 300, San Francisco, California 94111 in this matter.

6. Respondent understands the nature of the charges alleged in the Accusation and that, if proven at hearing, the charges and allegations would constitute cause for imposing discipline upon his certificate. Respondent is fully aware of his right to a hearing on the charges contained in the Accusation, his right to confront and cross-examine witnesses against him, his right to the use of subpoenas to compel the attendance of witnesses and the production of documents in both defense and mitigation of the charges, his right to reconsideration, appeal and any and all other rights accorded by

the California Administrative Procedure Act and other applicable laws. Respondent knowingly, voluntarily and irrevocably waives and gives up each of these rights.

7. In order to avoid the expense and uncertainty of a hearing, respondent admits to the allegations contained in paragraph 7 of the accusation in that on March 21, 2001, the Florida Board of Medicine issued a Final Order in case number 1994-077642 finding that respondent had violated Florida statutes as specified in the order and then issued a reprimand, imposed a fine, and ordered additional Continuing Medical Education courses, and community service. Respondent agrees that he has thereby subjected his California medical certificate to disciplinary action pursuant to Business and Professions Code section 141.

8. All admissions and recitals contained in this stipulation are made solely for the purpose of settlement in this proceeding and for any other proceedings in which the Division of Medical Quality, Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceedings.

9. Respondent acknowledges that he shall not be permitted to withdraw from this stipulation unless it is rejected by the Medical Board of California, Division of Medical Quality.

10. Based on the foregoing admissions and stipulated matters, the parties agree that the Division shall, without further notice or formal proceeding, issue and enter the following order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that

1. Respondent shall be, and hereby is, publicly reprimanded.

2. Respondent shall reimburse the Division the amount of $500 as recovery of reasonable costs of investigation and prosecution of this case within ninety (90) days of the Board's Order.

3. Any failure by respondent to comply with any term or condition of this order in any respect shall constitute unprofessional conduct and permit the Board at its sole, non-reviewable election to set aside and vacate its order of adoption herein.

4. The terms and conditions set forth herein shall be null and void and not binding on the parties unless and until approved on behalf of the Board.

ACCEPTANCE

I have read the above Stipulation for Public Reprimand. I understand the terms and ramifications of this Stipulation, and agree to be bound thereby. I enter this stipulation freely, knowingly, intelligently and voluntarily.

DATED: 8/14/02

Gary L. Lowery M.D., Ph.D

GARY LYNN LOWERY, M.D.
Respondent

I concur as to form.

DATED: 8/19/02

Charles O. Thompson, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulation for Public Reprimand is hereby respectfully submitted for the consideration of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs.

DATED: 9/9/02

BILL LOCKYER, Attorney General
of the State of California

GAIL M. HEPPELL
Supervising Deputy Attorney General

Attorneys for Complainant

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: GARY LYNN LOWERY, M.D. 10645 North Tatum Blvd., Suite 200, #614 Phoenix, AZ 85028 Physician and Surgeon's Certificate No. G 50591, Respondent.	Case No. 16-2001-121085 ACCUSATION

Complainant alleges:

PARTIES

1. Complainant, Ronald Joseph ("Complainant"), brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter "Medical Board").

2. On or about July 5, 1983, the Medical Board of California issued Physician and Surgeon's Certificate Number G 50591 to Gary Lynn Lowery, M.D. ("Respondent"). Said certificate expired on May 31, 2001.

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///

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code ("Code"):

A. Section 118(b) of the Code provides that "[t]he suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

B. Section 141 of the Code provides:

"(a) [f]or any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

C. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

D. Section 2427 (a) provides, in pertinent part, that "[e]xcept as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of all accrued renewal fees and any other fees required by Section 2424."

4. Section 14124.12 of the Welfare and Institutions Code provides, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

RECOVERY OF COSTS

5. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

6. Respondent is subject to discipline within the meaning of Code section 141(a) as more particularly set forth hereinbelow.

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FIRST CAUSE FOR DISCIPLINE
(Discipline, Restriction, or Limitation Imposed by Another State)
[Bus. & Prof. Code § 141(a)]

7. On or about March 21, 2001, the Florida Board of Medicine issued a "Final Order" in case number 1994-07642, finding that respondent violated subsection 458.331(1)(t) of the Florida Statutes by failing to practice medicine with "that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances." (See, "Recommended Order" at p. 19.) According to the Recommended Order that was, in relevant part, adopted by the Board, it was determined that, in a surgical procedure performed on a patient, "[r]espondent took and looked at the first intraoperative x-ray, miscalculated, did not call on other staff to assist in identifying the location level of operation, removed the wrong disc, took his own second x-ray without adequate landmarks, and failed to document accurately what he had actually done. He also failed to recognize his error in a timely manner; for six months, he did not connect the February 4, 1992, radiologist's report of a fusion at C6-7 with his pre-operative plan to fuse at C5-6; for six months took and looked at x-rays showing the C6-7 fusion and did not see the continuing problem at C5-6 despite L.R.'s complaints of pain; nor, by comparing his pre-surgical plan to successive post-operative x-rays, did he see that he operated at the wrong level of C6-7. Consequently, he also repeatedly failed to document in the patient's chart and/or his office notes that he had operated at the wrong level." (See, "Recommended Order at pp. 19-20.) In adopting the findings of the Administrative Hearing Officer, the Florida Board determined that respondent's conduct noted above failed to conform to the minimal standards of acceptable medical practice. The Florida Board thereupon issued a reprimand, imposed a fine of $10,000, directed that respondent attend Continuing Medical Education courses to document completion of these courses, and perform 50 hours of community service.

Attached as Exhibit "A" and incorporated by reference herein is a true and correct copy of the "Final Order" of the Board of Medicine of the State of Florida.

8. The actions alleged and discipline imposed by the Florida Board of Medicine against respondent, noted above, constitutes conduct that is substantially related to the

practice regulated by the California Medical Board and is subject to discipline within the meaning of Code section 141(a).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G 50591, heretofore issued to respondent Gary Lynn Lowery, M.D.;

2. Revoking, suspending or denying approval of Gary Lynn Lowery, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering, Gary Lynn Lowery, M.D., to pay the Division the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 7, 2001

RONALD JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant